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ABSTRACT

The vast majority of mentally ill offenders are not violent, although their illness necessarily manifests itself in ways that society often finds unacceptable. The number of mentally ill offenders is growing because needed mental health care is not available to those who are no longer hospitalized due to the deinstitutionalization movement and the restrictive civil commitment laws. Incarceration of persons with mental illness is likely to aggravate their conditions. To improve the status of mentally ill offenders: (1) communication and coordination among corrections, mental health, social services, and vocational rehabilitation departments should be improved; (2) training in handling the mentally ill should be provided for mental health and correctional staff; (3) the number of mentally ill offenders should be assessed to determine the resources needed to care these inmates; (4) the number of psychiatrists and psychologists in prisons should be increased; (5) medical schools should be encouraged to incorporate training with mentally ill disorderd offenders into their programs; (6) creative funding mechanisms and new sources should be identified; and (7) sufficient funding for effective community services should be provided. Practical planning strategies can be developed for the provision of at least minimum mental health services and for the improvement of linkages between jails and mental health agencies. (Specific programmatic and legislative responses of the states are included.) (ABL)

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MENTAL HEALTH PROJECT

Human Services Series

The Mentally Ill Offender: Punishment or Treatment

by

Rebecca Craig and Michelle Kissell

Vol. 13, No. 31 Updated September 1988

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THE MENTALLY ILL OFFENDER: PUNISHMENT OR TREATMENT?

- Anne, a 50-year-old divorced woman, was arrested on a charge of trespassing. She had entered a fast-food restaurant when it opened and remained until closing time. She returned the next morning and was arrested when she refused to leave at the request of restaurant management. Anne had a long history of psychiatric hospitalizations spanning the past 20 years. Her most recent hospitalization occurred two months before her arrest, and when she returned to her apartment after being released, the manager evicted her. It was at this point that she went to the restaurant, seemingly waiting for someone to see her plight and help her (1, p. 366).

- David, a 23-year-old man with an extensive history of hospitalizations, was arrested for breaking and entering into a friend's home for undetermined reasons. Placed on probation, he was released to a halfway house. However, he was put out of the house because of inappropriate behavior. He then began carrying around a dead mouse and was repeatedly kicked out of hotels because of the smell. Still carrying his mouse, he wandered the streets giving away his money, and was regularly arrested for loitering and trespassing (2, p. 71).

- After 14 years in state mental institutions, 58-year-old Helen was discharged back to her small-town community where she shared an apartment with her elderly sister. Within one year of her hospital discharge, she had been jailed seven times on such minor charges as disorderly conduct, trespassing and creating a public nuisance. According to the local sheriff, her sister was unable to control her, the mental hospital would not take her back and "there is no where else to put her" (3, p. 7).

These individuals have more in common than their mental illness: they have been repeatedly mishandled by community systems that are unable to meet their needs for structure, control and appropriate treatment. Similar cases can be found in nearly every locality across the country. These are the people who make up the ranks of the mentally ill offenders.

THE MENTALLY ILL OFFENDER: CAUGHT BETWEEN THE CRIMINAL JUSTICE AND MENTAL HEALTH SYSTEMS

The term "mentally ill offender" denotes individuals who enter the criminal justice system for widely varying reasons or offenses. While the vast majority of mentally ill offenders are not violent, their illness often manifests itself in ways that society finds unacceptable. They are generally arrested and incarcerated on such misdemeanor charges as disturbing the peace, shoplifting, vagrancy or trespassing. The term mentally ill offender also may describe those persons convicted of felony crimes that have been adjudicated guilty but mentally ill (GBMI) or those who become mentally ill while incarcerated. Many mentally ill offenders fall somewhere between these two ends of the spectrum.

Factors influencing the increasing number of mentally ill offenders. Two interrelated changes in the philosophy of the nation's mental health system have contributed to the emerging problem of the mentally ill offender. The deinstitutionalization movement of the 1960s and 1970s encouraged the release of thousands of mentally ill individuals from state hospitals to receive treatment at community mental health centers instead. Unfortunately, many community mental health programs were not adequately equipped to handle either the severity of the clients' illnesses or the numbers of individuals seeking community care. In addition, restrictive civil commitment laws followed on the heels of deinstitutionalization, making it more difficult to involuntarily commit a person with mental illness. In most states, "dangerousness" is the primary criterion for involuntary commitment, although "gravely disabled" is often an alternate criterion. Obtaining commitment on these grounds often proves difficult, if not impossible.

Although such restrictive criteria were enacted to protect the rights of persons with mental illness, often the mental health system prevents mentally disabled persons from receiving needed treatment. If family and friends cannot get treatment for the person with mental illness because his behavior does not fit the narrow civil commitment criteria, they may have little choice but to request police intervention. One study of a suburban police department's archives indicated that "families, friends and others in the community call on the police to act as agents of social control for mentally ill individuals whose behavior, although disruptive, does not meet criteria for civil commitment" (4, p. 976). Because the criminal justice system is "the system that can't say no," the individual with mental illness may be jailed as a criminal for lack of a more appropriate alternative.

Critics have charged that the result of deinstitutionalization policies and restrictive civil commitment laws has been the criminalization of persons with mental illness. Just how pervasive is the incidence of mental illness in the nation's jails and prisons? Unfortunately, a definite answer is difficult due to a lack of statistics, but it appears that greater proportions of individuals with mental illness are found in jails than in prisons (5, p. 20). One source estimates that, out of 6.2 million incarcerated in county and city jails each year, 600,000 of these are mentally ill (3, p. 1). In large cities, however, between 20 and 35 percent of jail inmates are estimated to be mentally ill (6, p. 1). Corrections officials calculate that 10 to 35 percent of state and federal prison inmates are seriously mentally ill (5, p. 19).

Although statistics are few, nearly all law enforcement personnel agree that the number of incidents involving persons with mental illness that require police attention has increased during the past 10 to 15 years. One study on the occurrence of such incidents in a suburban Pennsylvania community showed a 227.6 percent increase from 1975 to 1979 (4, p. 973). Individuals with mental illness also are arrested 20 percent more often than non-mentally ill persons (7, p. 24), in part because their behavior makes them highly visible and because the illness may escalate a confrontation with police. Even if police prefer not to make an arrest, they may have no choice if mental health facilities refuse to accept the individual.

The general shortage of resources within mental health systems may pressure practitioners to turn away individuals brought to hospitals or clinics by the police. In some states, resources are so scarce that a patient must be released from the state hospital system before additional patients can be admitted. Emergency room psychiatrists faced with overcrowding and understaffing may try to avoid admission, or they may simply disagree with the police officer's evaluation of the person's mental condition. In addition, some experts have identified a philosophical mindset among mental health professionals who do not want to treat or experience difficulties effectively treating "acting-out" offenders (8, p. 1). Faced with such odds, many police officers find it simpler to arrest the individual, thereby ensuring that he is off the streets receiving custodial care, however inappropriate.

Incarceration of persons with mental illness. Once arrested, incarceration is likely to aggravate the condition of individuals with mental illness. They often cannot understand why they have been locked up, and may respond with confusion, terror or rage. They are frequently unable to comply with jail rules and procedures. If not kept separated from the general population, mentally ill offenders are commonly preyed upon by other inmates, but if they are placed in solitary confinement for their own protection, they may deteriorate even to the point of suicide (3, pp. 3-4).

In addition to the dehumanizing experience of incarceration, jails are often unable to provide adequate mental health care to mentally ill inmates, thus further exacerbating their illness. Many jails do not have available funds to employ staff who are adequately trained to identify mental illness, much less provide emergency intervention or other appropriate treatment. A 1977 survey found that only 36 percent of those jails that house mentally ill and emotionally disturbed inmates have psychological counseling available (6, p. 2). Although metropolitan jails may have mental health resources, such facilities may be so overcrowded and

understaffed that inmates suspected of mental illness may be placed on a waiting list for psychiatric evaluation and treatment. In rural settings, such treatment may be nonexistent.

Lack of communication and collaboration between mental health and corrections personnel further impairs identification and treatment of persons with mental illness and increases recidivism. If the criminal justice system attempts to divert a mentally ill offender to the mental health system, they may find that community mental health providers are reluctant to accept "criminal" patients, especially ones arrested for violent acts. The mentally ill offender may be unable to cooperate with an outpatient treatment plan, or may refuse such treatment. Cases like this simply fall through the cracks between the two systems, only to reappear when the person is arrested again.

Persons with mental illness in prisons. Another facet of the controversy over mentally ill offenders concerns treatment of such individuals in state and federal prisons. Although experts estimate that the proportion of mentally ill inmates in prison is much less than in city and county jails, mental health treatment is nevertheless often inappropriate and in short supply. Nearly all prisons experience a chronic shortage of psychiatric staff. For example, in 1983, one state employed one part-time psychiatrist to cope with a prison population of approximately 7,200. With such a shortage of mental health personnel, individual therapy is nearly impossible. As a result, psychotropic drugs such as thorazine are often the only form of treatment available (5, p. 21).

A new development within the criminal justice arena could further complicate the situation. There are now 12 states (Alaska, Delaware, Georgia, Indiana, Illinois, Kentucky, Michigan, New Mexico, Pennsylvania, South Carolina, South Dakota and Utah) that provide for a "guilty but mentally ill" verdict, and the proportion of inmates with mental health problems can reasonably be expected to increase. The defendant convicted as GBMI may receive the same punishment that could be meted out to a non-mentally ill defendant, even though mental health evaluation and treatment during the term of incarceration is promised (9, pp. E1-E2). However, in general, the GBMI finding does not guarantee the mentally ill inmate any treatment beyond that available to other offenders. Thus, this additional load of prisoners in need of treatment adds further pressure to an already overloaded prison psychiatric unit.

GENERAL LEGISLATIVE GUIDELINES

As emphasis on community treatment moves into its third decade, the phenomenon of persons with mental illness incarcerated in jails and prisons continues to plague criminal justice and mental health officials alike. The issue of the mentally ill offender is complicated by many interrelated factors that defy simple remedies. However, the following suggestions are offered to improve the status of the mentally ill offender (10, pp. 58-61).

- Improve communications and encourage close coordination among corrections, mental health, social services and vocational rehabilitation departments. These systems need to communicate regularly in order to understand each department's capabilities and constraints and to promote more humane case management.

- Provide training for mental health and correctional staff. Staff in both systems need specialized instruction to enable them to properly handle the special needs of mentally ill offenders.

- Assess the number of mentally ill offenders in correctional institutions to determine the amount of resources necessary to properly care for such inmates.

- Increase the number of psychiatrists and psychologists in prisons. In most prisons, overwhelming caseloads make adequate treatment of mentally ill offenders impossible.

- Entice medical schools to incorporate training with mentally disordered offenders into their programs. Current psychiatric training does not encourage or prepare professionals to work with this population.

- Study creative funding mechanisms to maximize existing resources and identify new funding sources. Some mental health programs have incorporated revenue producing activities and other business management techniques to supplement declining public support.

- Provide sufficient funding to ensure effective community treatment services, including outpatient and residential care. More comprehensive local mental health programs would be less costly than the expense of shuttling the mentally ill between state hospitals, jails and courts.

THE STATES' RESPONSE IN RECENT YEARS

Legislation

Recent challenges to the insanity defense and outcries among the criminal justice and mental health systems have encouraged state legislators to address the needs of the mentally ill offender in a number of ways. During the 1986 session, at least 12 states considered legislation that would affect the laws and programs concerning mentally disturbed offenders.

Criminal procedure. A number of states, including Alabama (1982 Ala. Acts, Act 82-887 and Act 82-888), Colorado (1983 Colo. Sess. Laws, Chap. 188), Idaho (1982 Idaho Sess. Laws, Chap. 368), Indiana (1987 Ind. Acts, P.L. 209), Maryland (1984 Md. Laws, Chap. 501), Montana (1987 Mont. Laws, Chap. 267), New Hampshire (1987 N.H. Laws, Chap. 13), North Dakota (1985 N.D. Sess. Laws, Chap. 173 and 1983 N.D. Sess. Laws, Chap. 165), Oregon (1983 Or. Laws, Chap. 800), New York (1986 N.Y. Laws, Chap. 230), South Dakota (1986 S.D. Sess. Laws, Chap. 194), Texas (Tex. Penal Code Ann. § 8.01 (sub. A) (Vernon 1983) and Wisconsin (1987 Wis. Laws, Act 85 and Act 86) addressed criminal procedure relating to the mentally ill offender. Alabama (Act 82-888), Colorado, Idaho, New Hampshire, North Dakota, Oregon and Texas abolished, narrowed or revised the definition of insanity or mental condition as a defense in criminal proceedings. Alabama (Act 82-887), Maryland and New York examined standards, conditions and procedures for incarceration and release. New York allows a parole board to determine the parole of inmates serving indeterminate sentences with the mental health department. South Dakota now provides for the guilty but mentally ill verdict. Maryland (1987 Md. Laws, Chap. 418) and Wyoming (1987 Wyo. Sess. Laws, Chap. 109) prohibited the death penalty for mentally incompetent inmates.

Commitment. During recent years, at least seven states have passed legislation concerned with the involuntary commitment of mentally ill offenders, including Arizona (1983 Ariz. Sess. Laws, Chap. 92 and Chap. 287), Arkansas (1983 Ark. Acts, Act 917), California (1985 Cal. Stats., Chap. 1286, Chap. 1416, and Chap. 1418), Connecticut (1985 Conn. Acts, P.A.85-506), Florida (1982 Fla. Laws, Chap. 82-224), Kansas (1986 Kan. Sess. Laws, Chap. 134), Louisiana (1987 La. Acts, P.A. 928), Nevada (1987 Nev. Stats., Chap. 212), New Hampshire (1987 N.H. Laws, Chap. 405), and New York (1986 N.Y. Laws, Chap. 164). Arizona (Chap. 92) provides procedures for the involuntary commitment of prisoners found to be mentally ill to a state hospital or inpatient facility. California (Chap. 1286) provides for placement on outpatient status of persons convicted of felonies and sentenced to the state prison subject to the same procedures of mentally ill offenders committed to a state hospital. During the 1986 session, Maine (1986 Me. Laws, Chap. 630) passed legislation requiring that an examination of incarcerated prisoners be made to determine if commitment to a mental health facility is needed. In an effort to treat the mentally ill before they become involved in the criminal justice system, Michigan (1986 Mich. Pub. Acts, Act 117 and Act 118) has revised commitment procedures that now allow for voluntary treatment, short hospitalizations, and combined and

alternative treatment orders. New York now provides for the commitment and retention of inmates who suffer from a mental illness that is likely to result in serious harm to himself or others.

Treatment. In recent years, Arizona (1984 Ariz. Sess. Laws, Chap. 92), California (1985 Cal. Stats., Chap. 82, Chap. 1286, and Chap. 1419, and 1986 Cal. Stats., Chap. 848), Florida (Fla. Laws, Chap. 82-224), Kentucky (1986 Ky. Acts, Chap. 155), New Hampshire (1985 N.H. Laws, Chap. 337), New Jersey (1986 N.J. Laws, Chap. 71), Rhode Island (1987 R.I. Pub. Laws, Chap. 231 and Chap. 576), Tennessee (1986 Tenn. Pub. Acts, Chap. 483), and Texas (1985 Tex. Gen. Laws, Chap. 554 and S.C.R. 128, and 1987 Tex. Gen. Laws, Chap. 485) passed legislation concerned with the treatment of mentally ill offenders. In part, California (Chap. 1419) provides treatment of certain inmates who have mental disorders and authorizes such treatment as a condition for parole, renewable at one-year intervals. Florida now ensures that mentally ill inmates receive evaluation and appropriate treatment for their illnesses through a continuum of services. Kentucky mandates the provision of pyschiatric evaluation, treatment or services to prisoners. New Jersey required the formulation of a plan to provide adequate and appropriate mental health services to inmates in state-operated correctional facilities. Rhode Island now allows persons awaiting trial to be transferred to the Forensic Unit if the correctional facility cannot provide needed mental health care. Texas (S.C.R. 128) encourages the development of creative community-based alternatives for mentally disabled offenders.

Rights. Several states have attempted to address the various rights of the mentally ill offender in recent years, including Arizona (1984 Ariz. Sess. Laws, Chap. 287), Florida (1982 Fla. Laws, Chap. 82-2240 and 1986 Fla. Laws, Chap. 85-167) and Rhode Island (1987 R.I. Pub. Laws, Chap. 281). Arizona restricts the physician-patient privilege of confidential communication if any mental disability defense is raised in a criminal prosecution. Florida (Chap. 85-167) now provides for the rights of forensic clients, including confidentiality of clinical records, right to treatment and right of individual dignity. Rhode Island created a bill of rights for forensic patients committed for care and treatment under the laws governing persons "incompetent to stand trial" and "criminally insane" persons.

Studies. At least four states, California (1986 Cal. Stats., Chap. 1416 and Chap. 1286), New Mexico (H.J.R. passed in 1986), Tennessee (1985 Tenn. Pub. Acts, S.R. 21), and 1987 Tenn. Pub. Acts, H.J.R. 20), and Wisconsin (1985 Wis. Laws, S.J.R. 5), passed legislation to conduct studies affecting mentally ill offenders. California (Chap. 1286) will fund five counties to assess with county mental health and law enforcement agencies the adequacy and appropriateness of existing county mental health emergency response systems. Calfornia (Chap. 1416) also authorized an investigation into the prevalence of severe mental disorders among state prison inmates and parolees. New Mexico authorized an availability study of adequate mental health and detention facilities. Tennessee will study proposals for the treatment and alternatives to the housing of the mentally ill in the state corrections system. In 1987, Tennessee also urged the Department of Corrections to study the feasibility of having inmates and offenders who need psychiatric treatment work to reimburse state government for the cost of their treatment. Wisconsin will study problems related to the mental health services provided to prisoners.

Exemplary Local Programs

In addition to legislative efforts to improve the treatment of the mentally ill offender, many states have developed and implemented model programs that are effective and efficient in working with the mentally ill offender. The following model programs provide innovative examples of collaborative efforts between the mental health and criminal justice systems and effective treatment models that successfully deal with this disabled population. Summaries for the various state approaches were largely excerpted from Removing the Chronically Mentally Ill from Jail: Case Studies of Collaboration Between Local Criminal Justice and Mental Health Systems, National Coalition for Jail Reform, March 1984 (10).

Madison Police Department and Dane County Mental Health Center, Madison, Wisconsin. Through coordination between the Madison Police Department and the Dane County Mental Health Center, persons with serious mental illness have been successfully diverted from jail in Madison. A social service coordinator position serves as the liaison between the police and social service agencies. New police recruits and veteran officers receive training in identification and crisis intervention. Police can make referrals to a 24-hour crisis intervention program if necessary. The mental health center maintains several staff in the jail to identify and treat mentally ill inmates. In addition, the two systems collaborate in providing a mobile community treatment team to treat the most difficult and treatment-resistant persons. Funding for the program is provided by the Madison Police Department and the Dane County Mental Health Center.

Galveston County Mental Health Deputy Program, Galveston County, Texas. Initiated in 1975, the Galveston County Mental Health Deputy Program employs a team of deputies who specialize in dealing with emergency situations involving individuals with mental illness. In addition to their law enforcement duties, the deputies are trained in crisis intervention and emergency medical techniques. After deputies screen and evaluate an individual, either outpatient services are arranged for those not in urgent need, or the deputy appeals for legal action in order to transfer the client to a special hospital for emergency psychiatric evaluation. Permanent ongoing funding is being sought on a statewide basis from the Texas Mental Health and Mental Retardation Department and the Texas Criminal Justice Division for replication of the program in all urban county sheriff's departments within Texas.

The Mental Health Center of Boulder County Jail Program, Boulder, Colorado. Through an intensified jail mental health services and improved availability of psychiatric inpatient services to county residents, the Boulder County Jail population suffering from psychosis has been significantly reduced. A special mental health team provides regular on-site evaluations and treatment to jail inmates, with an emergency team providing 24-hour services for the seriously disturbed inmates. The clinical program of the mental health center evaluates mentally ill inmates, arranges the disposition of clients to appropriate treatment outside the jail when possible, provides treatment within the jail, serves as the liaison between involved nursing and corrections personnel, and provides limited training to jail personnel. The majority of psychotic offenders are transferred to treatment settings allowing for adequate psychiatric inpatient care or community support services.

San Gabriel Valley Region Mobile After Hours Crisis Intervention Program, Los Angeles County, California. Implemented in 1981, the Mobile After Hours Crisis Intervention Program provides rapid assistance in psychiatric emergency situations anywhere within the Los Angeles County community at times where traditional mental health services are not available. The mobile unit collaborates effectively with law enforcement officers in order to deter inappropriate incarceration in jail, and has helped to update crime prevention services in local communities. Clients admitted through the Mobile After Hours Crisis Intervention Program are assured of follow-through and continuity of care. The California Community Mental Health Act enables the program to be funded primarily by the state.

Monroe County Mental Health Clinic for Socio-Legal Services, Monroe County, New York. The Monroe County Mental Health Clinic was established in 1964 to meet the varied mental health service needs of the criminal justice system for the county's large urban/suburban/rural population. It provides judges and the courts with evaluations of defendants' competency to stand trial, comments on social risk and dangerousness, evaluates the need for treatment, assists with dispositional planning, as well as provides direct primary mental health care to those under the jurisdiction of the court. All inmates of the county jail, whether sentenced or unsentenced, are hospitalized immediately following a determination of need for psychiatric hospitalization. Individuals in jail requiring crisis intervention are seen immediately and county jail inmates have access to a comprehensive interdisciplinary mental health team during the work week. Funding for the clinic is dependent on funds allocated and dispersed by the Monroe County

manager and the county board, but an affiliation with the University of Rochester provides professional services at little or no cost to the county.

FUTURE TRENDS AND IMPLICATIONS

In its effort to resolve deviant or disruptive problems, society has allowed today's jails to become the storage place for many persons with mental illness. In addition, the police are using the criminal justice system as the last and frequently the only resort for care whether appropriate or not. The jail is now carrying the burden of the deinstitutionalization policies of the past. Individuals in need of mental health care have become so prevalent in detention faciiities that many consider this situation to be a priority management and treatment problem.

However, despite the protests of jail and mental health administrators that housing persons with mental illness in jail is inappropriate, this situation seems unlikely to change in the near future. The continued detention of mentally disordered persons in the criminal justice system most likely will be prolonged by three major factors (11, p. 3):

- An unlikelihood that the policies or procedures for state mental hospitalizations will drastically change;
- Society's continued intolerance of mentally disordered behavior and the use of the criminal justice system to resolve or remove the problem; and
- The continued budget reductions in mental health areas which will shift the financial burden to alternative institutions, including the jail and/or prison.

The future of the mentally disordered offender does not have to be a necessarily bleak and dismal picture. State and local governments can and have moved in many directions to greatly improve the care and treatment of the mentally disordered offender on both humanitarian and practical levels.

- Legislatures are funding commissions to develop local programs and processes between both the criminal justice and mental health systems for mentally disordered offenders;
- Localities across the country have implemented programs to divert mentally disordered offenders away from the criminal justice system into more appropriate services;
- Conservatorship is being used to provide on-going contact and monitoring for those individuals with mental illness in need of social controls; and
- Linkages between law enforcement and mental health personnel are improving communication between systems and improving service delivery.

Given the current realities of mental health and criminal justice financing at state and federal levels, it is unlikely that the vast array of services needed by both systems will be available in the near future. In addition, some medium to large jails across the country have begun to develop in-jail acute mental health treatment units when cooperative efforts between the mental health and criminal justice system have failed. However, practical planning strategies can be developed for the provision of at least minimum mental health services and for the improvement of linkages between jails and mental health agencies. Whatever the best long-range solutions, jails will continue to incarcerate individuals needing mental health services in the foreseeable future and both the mental health and criminal justice systems must plan accordingly.

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